COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

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To: State Retiree Health Benefits Program Participants Eligible for Medicare

From: Charles Reed, Associate Director
State and Local Health Benefits Programs

Date: November 19, 2003

Re: --Your Medicare Plan Monthly Rates Effective January 1, 2004
--Retiree Group Updates

Recipients of this Package: Retiree group participants receiving this package include Medicare-eligible Retirees, Survivors, Virginia Sickness and Disability Program Long Term Disability Participants and some eligible dependents who have separate, individual plans based on their Medicare eligibility.

Premium Rates for 2004: Medicare-eligible retiree group participants will experience premium increases effective January 1, 2004, as indicated below. Your premium increase is based on the claims costs of your individual plan. We are pleased to present premium increases for the Advantage 65 and Option I Plans that have a significantly lower percent increase than participants experienced for 2003. However, based on the individual expenses of the Option II Plan, its increase for 2004 is slightly (.6%) higher than the 2003 increase. The premium cost for the optional Dental/Vision coverage is unchanged.

Plan*	Current (2003) Single Premium	Your New 2004 Premium
Advantage 65	$236	**$244**
Advantage 65 + Dental/Vision	$263	**$271**
Medicare Complementary (Option I)	$201	**$216**
Medicare Supplemental (Option II)	$274	**$302**
Option II + Dental/Vision	$301	**$329**

*All State Retiree Health Benefits Program Medicare-coordinating plans are administered by Anthem Blue Cross and Blue Shield.

No Copayment, Coinsurance or Benefit Changes: All copayment and coinsurance levels will remain unchanged for 2004, and there will be no change to your plan benefits.

Making Allowable Plan Changes: If you wish to maintain your current plan and membership level, you do not need to take any action. Your new monthly premium will automatically be deducted or billed in the usual manner. If, due to the change in premium, your retirement annuity no long supports the deduction of your monthly premium, direct billing will automatically begin in December for your new January premium.

If you wish to make an allowable change in your coverage per plan provisions, your completed enrollment form must be received between December 1 and December 31, 2003, to ensure a January 1, 2004, effective date. Refer to the first page of the enrollment form for instructions about where to send your form. (You may also make changes using Employee Direct on the Web—by December 31 for a January 1 change.) All enrollment forms requesting a plan or membership change must be signed by the Enrollee (retiree, survivor or VSDP/LTD participant), not by a covered dependent. While some dependents receive packages addressed directly to them based on their separate plan coverage, only the Enrollee can authorize a plan or membership change. Requests for allowable changes received after December 31 will generally be effective the first of the month after receipt of the form (or receipt of the request through Employee Direct). Allowable changes (not associated with a qualifying mid-year event) include:

- **Removing dependents** (Dependents may not be added without the occurrence of a consistent qualifying mid-year event or, for non-Medicare Enrollees, at open enrollment.)
- **Adding Dental/Vision to Advantage 65 or Option II** (This is allowed one time only—if you have previously discontinued Dental/Vision coverage under either plan, you may not add it again to either plan.)
- **Removing Dental/Vision from Advantage 65 or Option II** (Once this coverage is removed, you will not have another opportunity to add it in the future.)
- **Moving between Option I and Option II** (Current participants may move between those plans or to Advantage 65, but once Option I or II participants elect Advantage 65 coverage, they may not move back to Option I or II again in the future.)

If you elect one of the above changes, check *"Medicare Eligible Member Making Allowable Plan Change"* as the reason the form is being submitted (see Part A), and follow all enrollment form instructions carefully.

ID Cards: If you make no change to your current program coverage, you may continue to use your current identification card. If you need a replacement card, please contact Anthem Member Services at 1-800-552-2682 (outside of Richmond) or 355-8506 (in Richmond). If you do make an allowable plan change, you will receive an updated card within approximately two weeks after your enrollment form (or Employee Direct change) is received.

Member Handbook Updates: A "Notification of Changes" to your Member Handbook is enclosed. This describes recent eligibility and administrative updates that affect your plan. Please review these changes carefully and keep them with your handbook. Participants in Advantage 65 + Dental/Vision and Option II + Dental/Vision will receive an additional Notification to update their Dental/Vision handbook. Complete new handbooks will not be issued at this time.

Extended Coverage: Enclosed you will find a general notice of your rights and the rights of your covered dependents to Extended Coverage. While Enrollees and their dependents covered in state Medicare-coordinating plans are receiving this notice individually as a part of this package, retiree group Enrollees and their dependents covered in state non-Medicare plans will receive notices at a later date.

Medicare-Eligible Participants: When an Enrollee (retiree, survivor, VSDP/LTD participant) or their covered dependent becomes eligible for Medicare prior to age 65, an enrollment form must be submitted immediately to elect a Medicare-coordinating plan (or you may use Employee Direct). It is the responsibility of the Enrollee to ensure adherence to this provision. Failure to do so could result in significant coverage deficits.

This is an important provision of the State Retiree Health Benefits Program. All participants who are eligible for Medicare, regardless of age, must enroll in both Parts A and B in order to get the full benefit of any state Medicare supplemental coverage since Medicare becomes the primary payer of claims. If it is determined that a retiree group participant is eligible for Medicare and has not enrolled in a Medicare-coordinating plan, he or she will be placed in the Advantage 65 Plan immediately, and primary claim payments made in error may be retracted. (The addition of Dental/Vision coverage to Advantage 65, if elected, will be effective the first of the month after an enrollment form is received.) If participants have declined their Medicare Part B coverage, it could result in a delay in Part B enrollment and, as a result, a critical gap in coverage until Part B goes into effect.

Prompt Payment of Premiums: Plan participants are responsible for timely payment of their monthly premiums (either through annuity deduction or by direct payment to the carrier). Participants who pay directly to the carrier receive monthly bills which indicate when premium payments are due. Monthly premiums that remain unpaid for 31 days after the due date will result in termination of coverage. Once an Enrollee and his/her dependent(s) have been terminated for non-payment of premiums, re-enrollment in the program is not allowed except in extreme extenuating circumstances.

Participants are responsible for understanding their premium obligation and for notifying the program within 31 days of any qualifying mid-year event that affects eligibility and/or membership level. Premium overpayments due to failure of the enrollee to advise the program of membership reductions may result in loss of the overpaid premium amount.

Revised Eligibility for Dependent Children: It is the responsibility of the Enrollee to remove any dependents who lose eligibility for coverage under the provisions of the State Retiree Health Benefits Program. As provided in the Administrative Code of Virginia, failure to do so can result in exclusion from the program for up to three years and prosecution by the Office of the Attorney General.

The definition of eligible children has been revised as follows:

- The retiree's unmarried biological or legally adopted children through the end of the year in which they reach age 23* as long as they live at home and are eligible to be claimed on the parent's federal income tax return, or children placed in the home under a pre-adoptive agreement which has been approved by the Department of Human Resource Management. Children will be considered as living at home if they live with the other parent (if the employee is divorced) or if the child lives away from home while attending college or boarding school.
- Unmarried stepchildren living full time with the retiree in a parent-child relationship and who are claimed on the retiree's federal tax return.
- Adult children with disabilities who are approved per plan provisions.
- Other children may be covered based on permanent legal custody ordered by a court and given to a retiree and/or spouse, as approved by the Department of Human Resource Management.

Consult your Benefits Administrator or Retiree Fact Sheet #2, *Eligibility, Enrollment and Plan Choices* if you need additional information regarding dependent eligibility for the program. The Virginia Retirement System (VRS) acts as Benefits Administrator for their own retirees, survivors and VSDP/LTD participants. Other retirees (e.g., Optional Retirement Plan or local retirees and their dependents) should contact their pre-retirement agency's Benefits Administrator for assistance.

Resources for Retiree Group Enrollees: In addition to your Benefits Administrator and your plan's member handbook, there are many resources available on the Department of Human Resource Management's Web site to provide information to retiree group participants about their State Retiree Health Benefits Program coverage. Just go to www.dhrm.state.va.us, click on the *Compensation and Benefits* link, and select *Health Benefits for Retirees, LTD Participants and Survivors*. Retiree Fact Sheets, which are available at this link, contain subject-specific information directed to retiree group participants.

Address Changes: Was this package forwarded to you from an old address? If so, be sure to contact your Benefits Administrator immediately to make an address correction. Failure to update your address can result in your missing important information about your health benefits program. The Department of Human Resource Management cannot be responsible for information that participants miss because their address of record has not been corrected. The Department's only means of communicating important information to retiree group participants is through the mail. Please let us know when you move!

Note to LTD Participants: Currently, eligible LTD participants who "waive" (not cancel) coverage based on plan provisions, and who maintain their waive status, can return to the State Retiree Health Benefits Program prospectively at any time, but only in single coverage. This provision will be revoked on June 30, 2004. Effective July 1, 2004, LTD participants in waive status will only be allowed to return to the program upon the occurrence of a consistent qualifying mid-year event or (for non-Medicare participants only) at open enrollment. Please keep this new plan provision in mind if you are able and choose to waive your coverage prior to July 1, 2004.

Note to Option II Participants: Since January 1, 2003, Option II participants have had access to a prescription drug card in order to facilitate automatic filing of claims by participating pharmacy providers. For Option II participants who require diabetic supplies, this means that claims for insulin, syringes and lancets purchased from a participating pharmacy will also automatically be filed by the participating pharmacy. However, claims for insulin pumps, home glucose blood monitors and blood glucose test strips must be filed using an Anthem claim form. For additional information, contact Anthem Member Services at 1-800-552-2682 (outside of Richmond) or 355-8506 (in Richmond).

Newsletter: Please take a moment to read the enclosed *Open Forum* newsletter, which contains items of interest directed at retiree group participants.

Enclosures:

- Enrollment Form
- *Open Forum* Newsletter
- Member Handbook(s) *Notification of Changes*
- Extended Coverage *General Notice*

YOUR EXTENDED COVERAGE RIGHTS UNDER THE PUBLIC HEALTH SERVICE ACT

November 2003

Introduction

You are receiving this notice because you are covered under the Commonwealth of Virginia's Health Benefits Program or Retiree Health Benefits Program (the Plan). This notice contains important information about your right to Extended Coverage, which is a temporary extension of coverage under the Plan. The right to Extended Coverage was defined for private employers by federal law through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and these rights are reflected in the continuation coverage provisions of the Public Health Service Act which covers employees of state and local governments. Extended Coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains Extended Coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your Extended Coverage rights. For more information about your rights and obligations under the Plan and by law, you should contact your Benefits Administrator.

Your Benefits Administrator is the individual designated by your employing agency (for active employees), the Virginia Retirement System (for retiree group participants), or your pre-retirement agency (for Optional Retirement Plan or Local retiree group participants) to administer eligibility for the Plan, including Extended Coverage. Contact the Human Resources Department of the appropriate entity (as previously noted) to determine the name and mailing address of your specific Benefits Administrator. See the "If You Have Questions" section on page four for additional information regarding resources.

Extended Coverage

Extended Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. Extended Coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees or retiree group participants, and dependent children of employees or retiree group participants may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect Extended Coverage must pay the full cost of coverage plus an administrative fee.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan due to the occurrence of any of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee or retiree group participant, you will become a qualified beneficiary if you will lose your coverage under the Plan due to the occurrence of any of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan due to the occurrence of any of the following qualifying events:

- The parent/employee/retiree group participant dies;
- The parent's/employee's hours of employment are reduced;
- The parent's/employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced, causing the child(ren) to lose eligibility; or
- The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer Extended Coverage to qualified beneficiaries only after the Benefits Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee or retiree group participant, the Commonwealth of Virginia will be responsible for providing qualified beneficiaries with their right to elect Extended Coverage.

For other qualifying events (divorce of the employee/retiree group participant and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you (or any individual representing the qualified beneficiaries) must notify your Benefits Administrator. The Plan requires you to notify the Benefits Administrator within 60 days of the date coverage would be lost due to the qualifying event. Your designated Benefits Administrator must be provided with written notification including the following information:

- The type of qualifying event (e.g., divorce, loss of dependent eligibility);
- The name of the affected qualified beneficiary (e.g., spouse or dependent child);
- The date of the qualifying event;
- Documentation to support the occurrence of the qualifying event (e.g., final divorce decree, dependent child's marriage certificate, proof of child's self-support);
- The written signature of the notifying party.

Once the Benefits Administrator receives timely notice that a qualifying event has occurred, Extended Coverage will be offered to the qualified beneficiaries. For each qualified beneficiary who makes a timely Extended Coverage election (as defined in the Election Notice), Extended Coverage will begin on the date that Plan coverage would have been lost due to the qualifying event. Failure to provide timely and complete notification of the qualifying event will result in loss of Extended Coverage eligibility.

Extended Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee or retiree group participant, your divorce, or a dependent child losing eligibility as a dependent child, Extended Coverage lasts for up to 36 months.

Coverage that is terminated in anticipation of a qualifying event (e.g., divorce) is disregarded when determining whether the event results in a loss of coverage. Upon receiving notice of the

event, as defined above, the Benefits Administrator must make Extended Coverage available and effective on the date of the event, but not before.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, Extended Coverage lasts for up to 18 months. There are two ways in which this 18-month period of Extended Coverage can be extended.

Disability Extension of 18-Month Period of Extended Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of Extended Coverage and you notify your Benefits Administrator in a timely fashion (as defined below), you and your entire family can receive up to an additional 11 months of Extended Coverage, for a total maximum of 29 months. You (or any individual representing the qualified beneficiaries) must make sure that your Benefits Administrator is notified in writing of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of Extended Coverage. In addition, the following information must be provided in writing:

- The name of the affected qualified beneficiary (e.g., spouse or dependent child);
- The date of the determination;
- Documentation from the Social Security Administration to support the determination;
- The written signature of the notifying party.

Failure to provide timely and complete notification of the disability determination will result in loss of eligibility for the extension.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving Extended Coverage, the spouse and dependent children in your family can get additional months of Extended Coverage up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies or gets divorced. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you (or any individual representing the qualified beneficiaries) must make sure that your Benefits Administrator is notified of the second qualifying event within 60 days of the date coverage would be lost due to the second qualifying event. This notice must be delivered (by mail or hand delivery) to your Benefits Administrator in writing and include the following information:

- The type of second qualifying event (e.g., divorce, loss of dependent eligibility);
- The name of the affected qualified beneficiary (e.g., spouse or dependent child);
- The date of the second qualifying event;
- Documentation to support the occurrence of the second qualifying event (e.g., final divorce decree, dependent child's marriage certificate, proof of child's self-support);
- The written signature of the notifying party.

Failure to provide timely and complete notification of the second qualifying event will result in loss of Extended Coverage eligibility.

In addition, when an employee's qualifying event (e.g., termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare, the employee's covered spouse and dependent children (but not the employee) become entitled to Extended Coverage for a maximum period that ends 36 months after the Medicare entitlement.

If You Have Questions

This notice is intended as a summary of your Extended Coverage rights but does not completely describe Extended Coverage. If you have additional questions about Extended Coverage, you should contact your Benefits Administrator or the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Active or former employees (and their covered dependents) may contact the designated Benefits Administrator within their employing agency. Retiree group participants (and their covered dependents) should contact the Virginia Retirement System or, for Optional Retirement Plan or Local Retirees (and their covered dependents), their pre-retirement agency's Benefits Administrator. The EBSA can address provisions of COBRA that also apply to the Public Health Service Act. Addresses and phone numbers are available through EBSA's Web site at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep your Benefits Administrator informed of any changes in your address or the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Benefits Administrator.